RESET

EMAIL TO:

GENERAL SERVICES ADMINISTRATION
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505

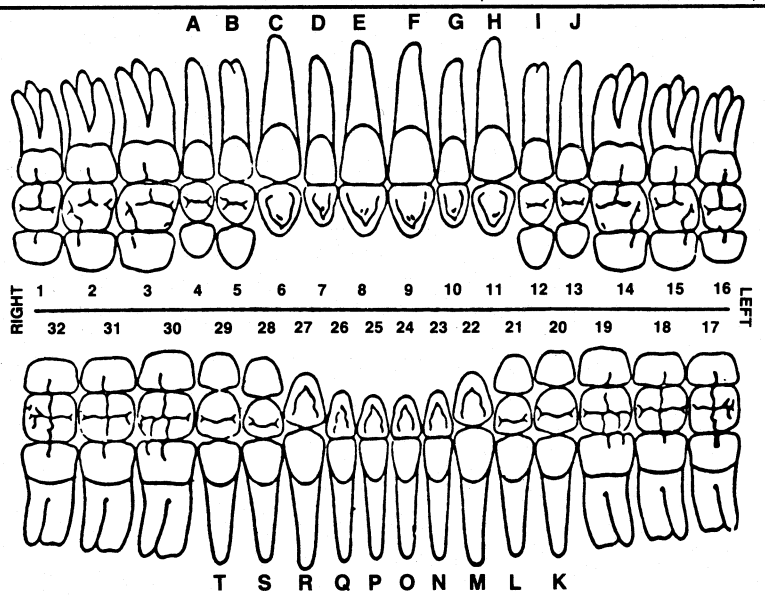
HEALTH RECORD | **DENTAL**

SECTION I. PRESENTING DENTAL STATUS

PAGE: 1

1. PURPOSE OF EXAMINATION	2. TYPE OF EXAM.	3. DENTAL CLASSIFICATION
☐ INITIAL ☐ SEPARATION ☐ OTHER *(Specify)*	☐ 1 ☐ 2 ☐ 3 ☐ 4	☐ 1 ☐ 2 ☐ 3 ☐ 4

4. MISSING TEETH, EXISTING RESTORATIONS, AND PROSTHETIC APPLIANCES



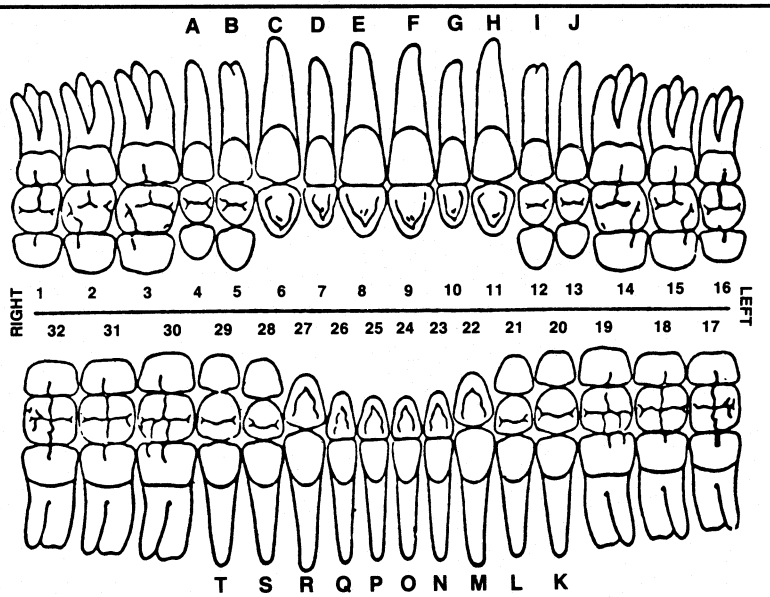
REMARKS

USE ONLY IF DIFFERENT FROM BOX 7 BELOW

PLACE OF EXAMINATION	DATE

SIGNATURE OF DENTIST COMPLETING THIS SECTION

5. DISEASES AND ABNORMALITIES



REMARKS

7. EXAMINING DENTIST AND FACILITY

PLACE OF EXAMINATION	DATE

SIGNATURE OF DENTIST

6. INDICATE X-RAYS USED IN THIS EXAMINATION

☐ PANORAMIC RADIOGRAPHS	☐ FULL MOUTH PERIAPICAL	☐ POSTERIOR BITE-WINGS	☐ OTHER:	☐ NONE TAKEN

PATIENT'S IDENTIFICATION *(Use this Space for Mechanical Imprint)*

PATIENT'S NAME *(Last, First, Middle Initial)*			SEX
DATE OF BIRTH	RELATIONSHIP TO SPONSOR	COMPONENT/STATUS	DEPART/SERVICE
SPONSOR'S NAME			RANK/GRADE
SSN OR IDENTIFICATION NO.		ORGANIZATION	

EXCEPTION TO SF 603
APPROVED BY GSA/IRMS 1-91

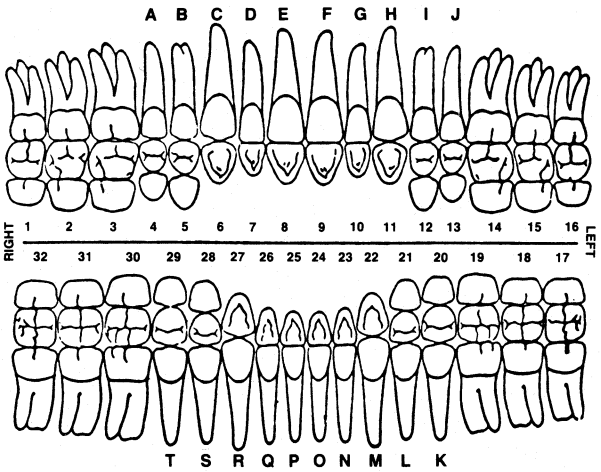
DENTAL
Standard Form 603
(Rev. 10-75)

S/N 0105-LF-011-9300

SECTION II. CHRONOLOGICAL RECORD OF DENTAL CARE

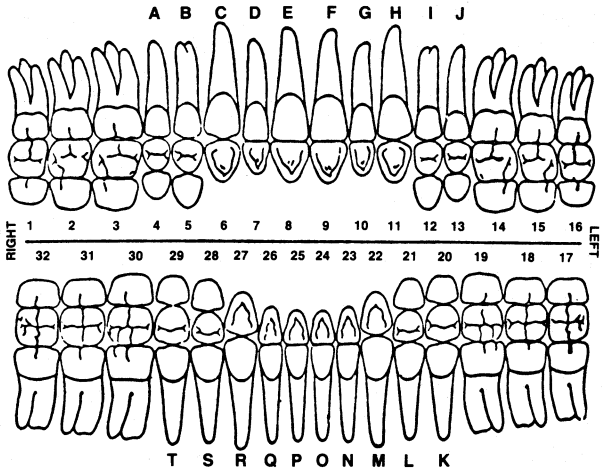
PAGE:

8. RESTORATIONS AND TREATMENTS *(Completed during service)*



REMARKS

9. SUBSEQUENT DISEASES AND ABNORMALITIES



REMARKS

10. SERVICES PROVIDED

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, PROVIDER, TREATMENT FACILITY *(Sign each entry)*		CLASS

PATIENT'S NAME:

SSN:

SF 603 (SIDE 2)

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